



## MEDICAL/LIABILITY RELEASE

**NOTE:** The sport of Water Polo is classified as a “physical contact sport” and athlete participation can, and occasionally does, result in athlete injury. Although most injuries are minor, serious and even life threatening injuries can occur, requiring immediate medical emergency services, care and treatment. Lamorinda Water Polo, Inc. (LWP) is a member of United States Water Polo (USAWP). Each and every registered LWP athlete must also be a member of USAWP, (no exceptions). As such, USAWP member coaches, officials, member athletes and clubs are covered with general liability insurance. For the safety of LWPs’ athletes, coaches, officials and as required for the use of the pool sites all registered LWP athletes must have the following Medical/Liability Release on file for participation with and under the auspices of Lamorinda Water Polo, Inc.

## MEDICAL/LIABILITY RELEASE

This is to certify that I \_\_\_\_\_, as parent/guardian for \_\_\_\_\_, acknowledge the aforementioned risks associated with the sport of Water Polo and participation with Lamorinda Water Polo, Inc. (LWP) (domestically and internationally) to include, but not limited to, all practices, tournaments, traveling to and from said events.

Further, I consent to and authorize any adult LWP coach/trainer (or any adult so directed by a LWP. coach/trainer) to seek and obtain qualified medical emergency services, care and treatment for the aforementioned registered LWP athlete should the need arise. He/she is to do so in a timely manner and every attempt is to be made to contact me.

Additionally, I agree to be fully responsible for any and all expenses incurred and related to any such medical emergency, care and treatment. I agree to hold LWP and all others harmless for such expenses/liability except as provided by the USAWP membership of said athlete and that provided under USAWP for Lamorinda Water Polo, Inc. membership and/or the athlete’s personal and private medical insurance providers.

### Registered Athlete

Name \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_ DOB \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Phone Number \_\_\_\_\_

### Medical Insurance/Information

Provider \_\_\_\_\_  
Address \_\_\_\_\_  
Phone Number \_\_\_\_\_ Group/Policy Number \_\_\_\_\_  
Responsible Party \_\_\_\_\_  
Athletes Primary Physician \_\_\_\_\_ Phone Number \_\_\_\_\_  
Athletes Dentist \_\_\_\_\_ Phone Number \_\_\_\_\_  
Special Medical Needs \_\_\_\_\_

Parent/Guardians Signature \_\_\_\_\_ Date \_\_\_\_\_  
Parent/Guardian Name (PRINT) \_\_\_\_\_  
Relationship to Registered Athlete \_\_\_\_\_  
Athlete’s Signature \_\_\_\_\_ Date \_\_\_\_\_